

**SECTION
VI**

THE DC HEALTHCARE ALLIANCE A PUBLIC—PRIVATE PARTNERSHIP

Since its inception in July 2001, the DC Healthcare Alliance has been the centerpiece of the Mayor's 1999 Healthcare Reform Initiative. The goal of establishing the Alliance was to provide eligible uninsured residents of the District of Columbia open access to quality healthcare.

The Alliance was established to serve those citizens who meet the following criteria:

- District of Columbia residency
- No other form of health insurance
- Family income at or below 200 percent of the Federal Poverty Level

The public/private partnership is comprised of the following entities.

Public Partner

DC Department of Health, Health Care Safety Net Administration is the Contracting Agency of the DC Healthcare Alliance.

Private Partners

Greater Southeast Community Hospital

- Serves as primary contractor for Alliance Program Operations and Management
- Manages the DC General Ambulatory and Urgent Care Services
- Provides inpatient and trauma services
- Provides services to Department of Corrections patients.

Unity Healthcare

- Operates community-based primary care clinics that are dispersed across the District.

George Washington University Hospital

- Hospital inpatient and specialty services and trauma specialty care

Children's National Medical Center

- Pediatric hospital services including trauma and specialty care
- Pediatric specialty and primary care
- School Health Program Services (school nurses).

Chartered Healthcare

- Administrative Services (Member Services, Claims Payment, MIS Support)
- Enrollment/eligibility and Network Provider Management
- Quality Management/Coordination of Care
- Health education/wellness programs and services
- Data gathering and program reporting.

DC General Hospital

- The campus is home to a 24-hour free standing Emergency Room and Ambulatory Care Center.¹

¹ The professional medical staff provides health services 24 hours a day 365 days per year. Pharmacy services are also provided at the site.

PROVIDERS IN THE NETWORK

The DC Healthcare Alliance brings together a full spectrum of providers necessary to deliver a continuum of care into a single integrated network with the goal of meeting the healthcare needs of the District's uninsured residents. While the prime responsibility for inpatient care rests with Greater Southeast Community Hospital, at present there are a total of six hospitals distributed across the District that are providing inpatient care services through subcontractual arrangements. The Alliance Hospitals Partners are:

- Greater Southeast Community Hospital Center (Greater Southeast)
- Children's National Medical Center (Children's)
- Providence Hospital
- George Washington University Hospital
- Washington Hospital Center
- Howard University Hospital.

Primary Care

In addition to the hospitals that provide acute care services in either emergent or inpatient settings, the Alliance is focused on the promotion of community-based, preventive care through a network of community clinics. The two important community-based organizations that are involved in this aspect of the program include:

- Unity Health Care – 6 clinics located across the District
- Nonprofit Consortium of Clinics – 20 clinics located across the District

The extent and distribution of the primary care network is displayed in the map in Section 5 (Chart 5.1).

The Alliance is also composed of numerous primary care and specialty physicians that are independently contracted providers. Because the goal of the program is centered around provision of a primary care medical home for all eligible uninsured in the District of Columbia, the focus of the initial efforts of the Alliance has been to build an adequate network of primary care physicians. As of May 2002, the total number of primary care providers was 216 and the total enrolled population was 28,557.

PROFILE OF ALLIANCE PATIENTS

When creating a new healthcare program, it is important to understand the population that it will serve. In the case of the Alliance, the program is designed to care for the neediest residents of the District. To determine the services, programs, and care plans that would provide the maximum benefit to this group, decision makers need to understand the population profile of the Alliance membership.

The analysis looks at the entire Alliance population. This includes those who were full members for any 6-month period in Year 1 as well as those members given 30-day presumptive eligibility. The presumptively eligible are profiled as a separate population in Section 9.

Age and Gender Comparisons

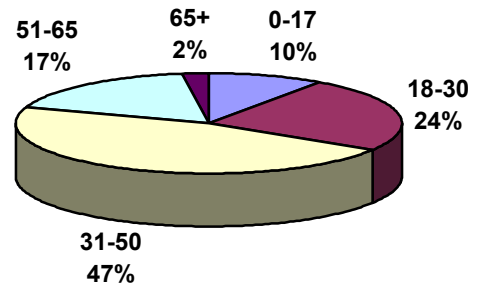
Comparing the Alliance to DC General Hospital (DCGH) by age and gender, we find that the distributions within each population are very similar in these two respects. Yet in comparing the two groups, a number of revealing observations were made.

- There were more men than women in the DCGH group as compared to an almost equal number in the Alliance group.
- The Alliance enrolled fewer children overall than the previous DCGH population had by at least 5 percent. This was a goal from the outset, since most children without insurance should be accessing other programs.
- Both populations had the majority of patients in the 31-50 age category.
- In the 18-30 age category, there were more Alliance females than males by approximately 3 percent. This may be

due to gender-specific healthcare needs like childbearing and prenatal issues. However, Alliance females outnumbered DCGH females by almost the same amount.

- The majority of the four populations (Alliance men and women and DCGH men and women) were clustered in the population with ages between 31-50. Within this age group, there were approximately 3 percent more males than females in the Alliance. This may be related to differences in utilization patterns or disease conditions, since most Alliance patients seek membership when they need services.

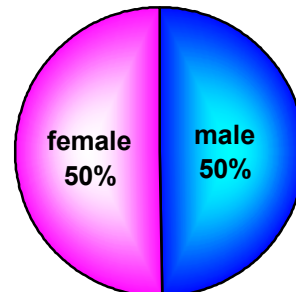
Alliance Members By Age
N = 37,614



Data source: HCSNA Data

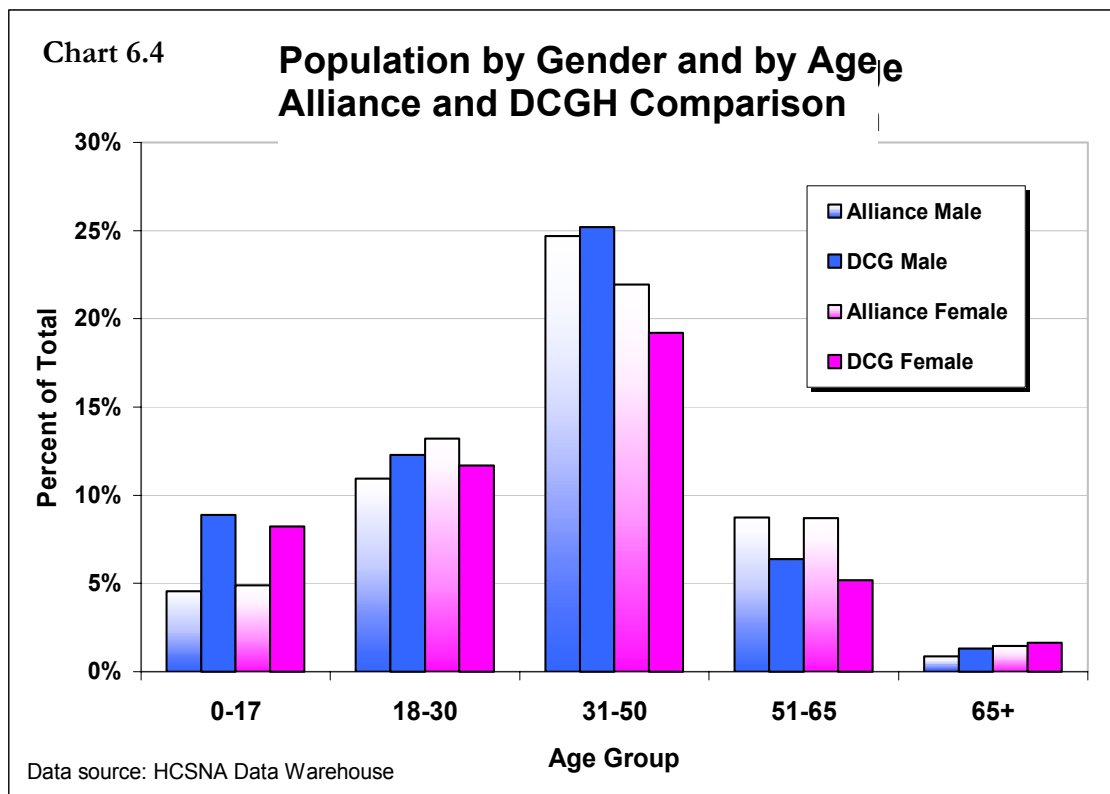
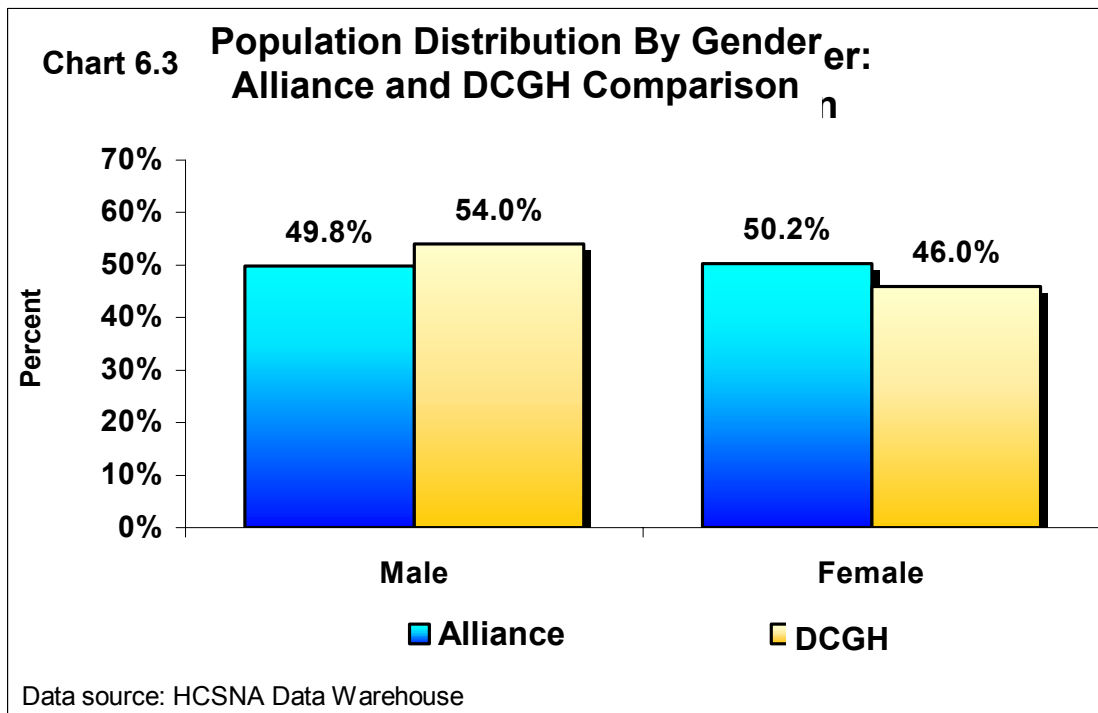
Chart 6.1

Alliance Members By Gender
N = 37,614



Data Source: HCSNA Data Warehouse

Chart 6.2

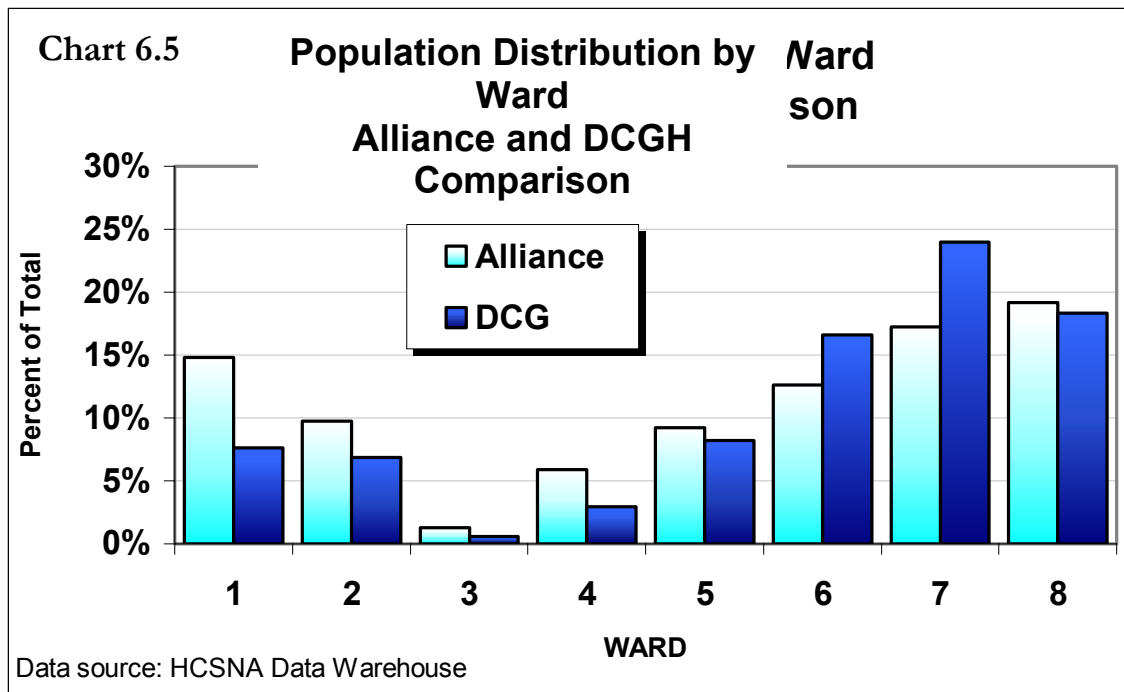


The Alliance Population by District Location

District ward location was determined by looking at the zip code of Alliance members at the time of enrollment in the Alliance. The HCSNA was able to match over 90 percent of the enrolled population to its

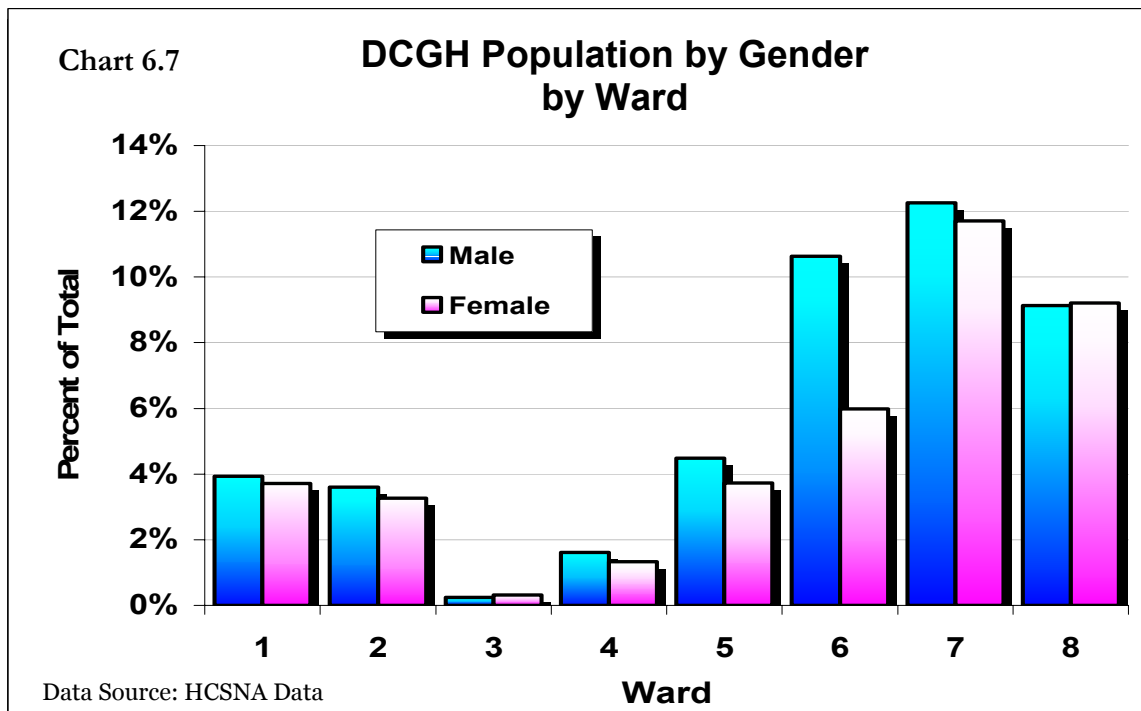
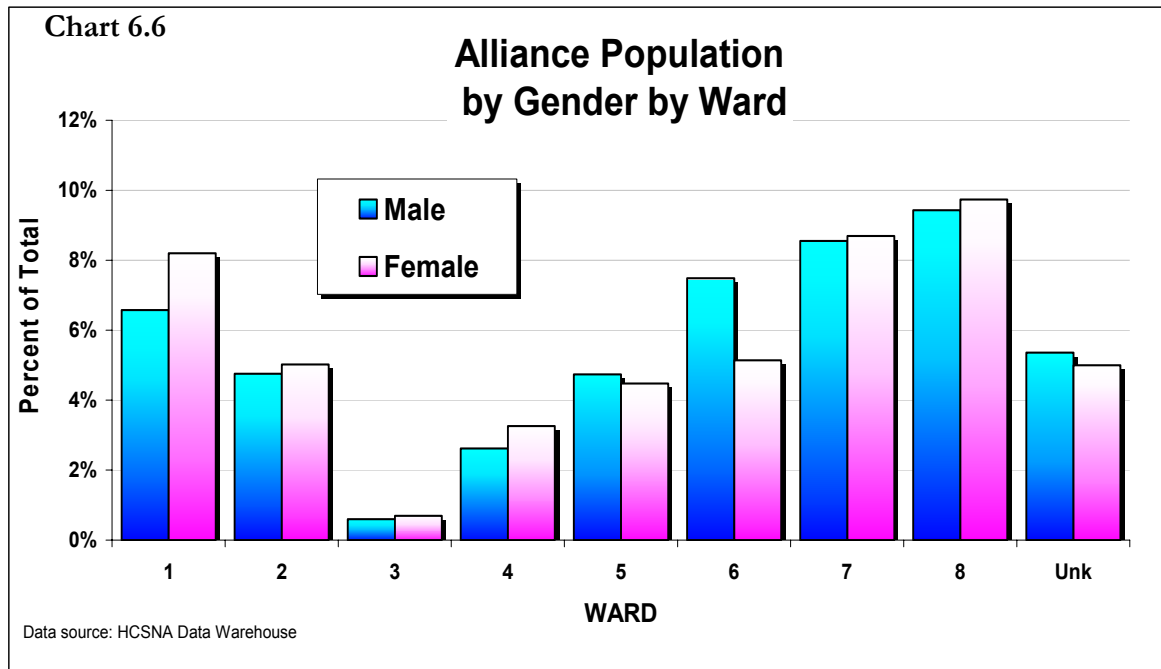
correct ward designation. The approximately 10 percent with unknown ward information in the Alliance can be explained by the number of homeless and those with incorrect or incomplete addresses at the time of service/enrollment in the Alliance.

Table 6.1 Percent of Service Population Distributed by Ward of Residence			
	Alliance N = 37,614	DCGH N = 37,962	Change in Ward Number Served (percent)
Ward 1	14.8%	7.7%	93.2%
Ward 2	9.8%	6.9%	42.4%
Ward 3	1.3%	0.6%	131.4%
Ward 4	5.9%	2.9%	99.5%
Ward 5	9.2%	8.2%	12.3%
Ward 6	12.6%	16.6%	-24.0%
Ward 7	17.3%	24.0%	-28.0%
Ward 8	19.2%	18.3%	4.5%

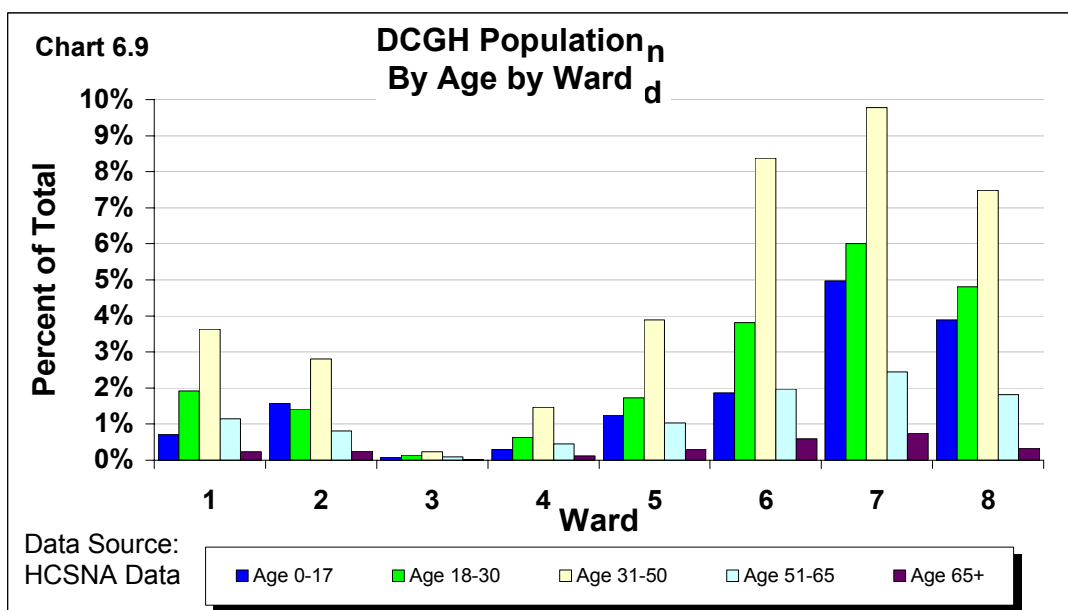
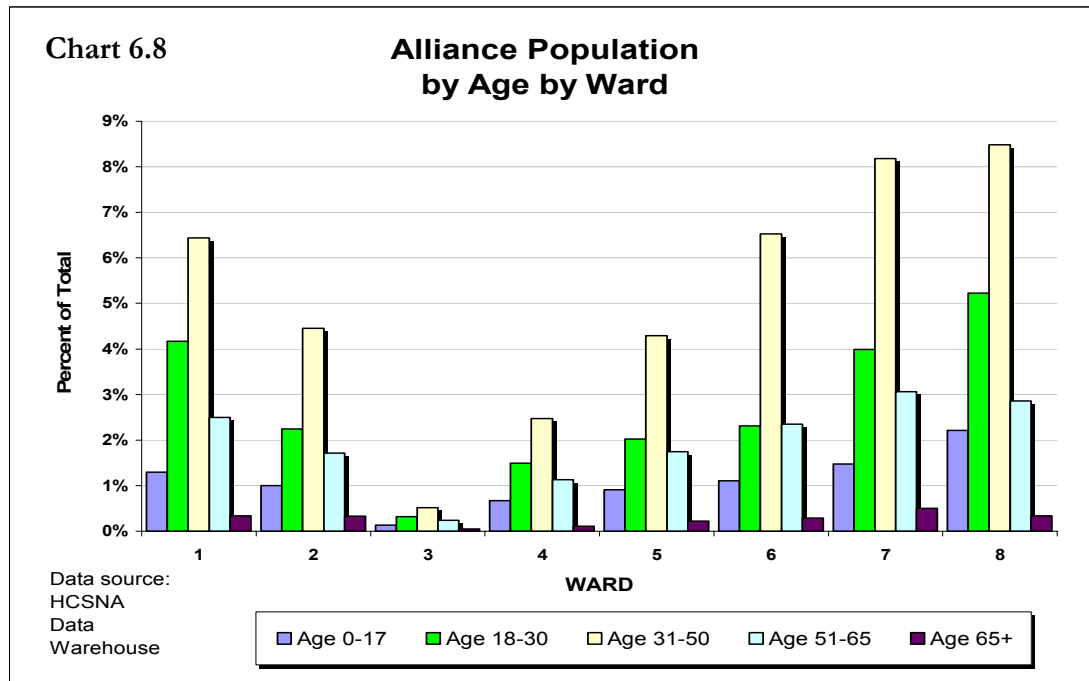


The charts show the following:

- The majority of the Alliance population is clustered in 4 wards: 8, 7, 1, and 6 as ranked highest to lowest
- The majority of the DCGH population was clustered in 4 wards: 7, 8, 6, and 5, as ranked highest to lowest
- The differences in the populations by ward are significant. Of particular interest are Wards 6 and 7. While still in the Alliance top rankings, each had membership that was roughly 25 percent and 30 percent lower than DCGH respectively



- Ward 8 had an Alliance membership that was 4 percent greater than the DCGH population
- Ward 1 had almost twice as many Alliance members as the DCGH
- The Alliance age distribution by ward is consistent with the overall population distribution. There are no wards with disproportionate shares of any particular age group.



Alliance Population by Ethnicity

The data on race and ethnicity of Alliance members was collected beginning in January 2002 by Chartered Health Plan. It is a self-identified, self-reported data element. As a snapshot of the Alliance population, the ethnic distribution of enrollees as of August 2002 is as follows:

Race and Ethnicity	Percent
African American/Black	74
Hispanic	22
Caucasian	2
Asian American	1
Native American	.001

Please note the ethnicity distribution is based on approximate percentages of the total number of enrolled members at the time of analysis. The HCSNA will provide updates on this statistic in future reports.

Conclusions

The Alliance membership as representative of the overall DC uninsured population is more diverse than originally thought.

The Alliance is serving generally the same population as DCGH did in terms of age, gender, and location.

The District, through the HCSNA, now has the information to target specific populations and neighborhoods for outreach, enrollment, and disease and care management.

As the Alliance program matures and the population stabilizes, future studies and more detailed levels of analysis will likely

point to areas of change. Such studies may include detailed analysis of specific wards, age, or ethnic groups, and how those characteristics are tied to disease categories.

Healthcare programs and services such as prepregnancy screens, well mother visits, and other similar programs may need to be better advertised within the Alliance, since women ages 18-30 represent almost 14 percent of the Alliance population.

DISEASE PROFILE

As the transition occurred from a hospital-based system of care to a patient-centered model with increased access to care, one of the goals of the Alliance and a measurement indicator for the HCSNA was disease prevention and management within the enrolled population. This population as a whole posed a number of public health challenges and presented a number of chronic diagnoses that would require patient education and focused service delivery to address.

Hypertension

Across gender and service categories (emergency room, inpatient, and out patient), the top diagnosis within the Alliance in the adult population was hypertension. As a disease category, it represented almost 20 percent of the total Alliance population who received services in Year 1. In looking at DC General baseline visit information, hypertension was the top outpatient diagnosis based upon visits for the same time period within the prior year.

Diabetes

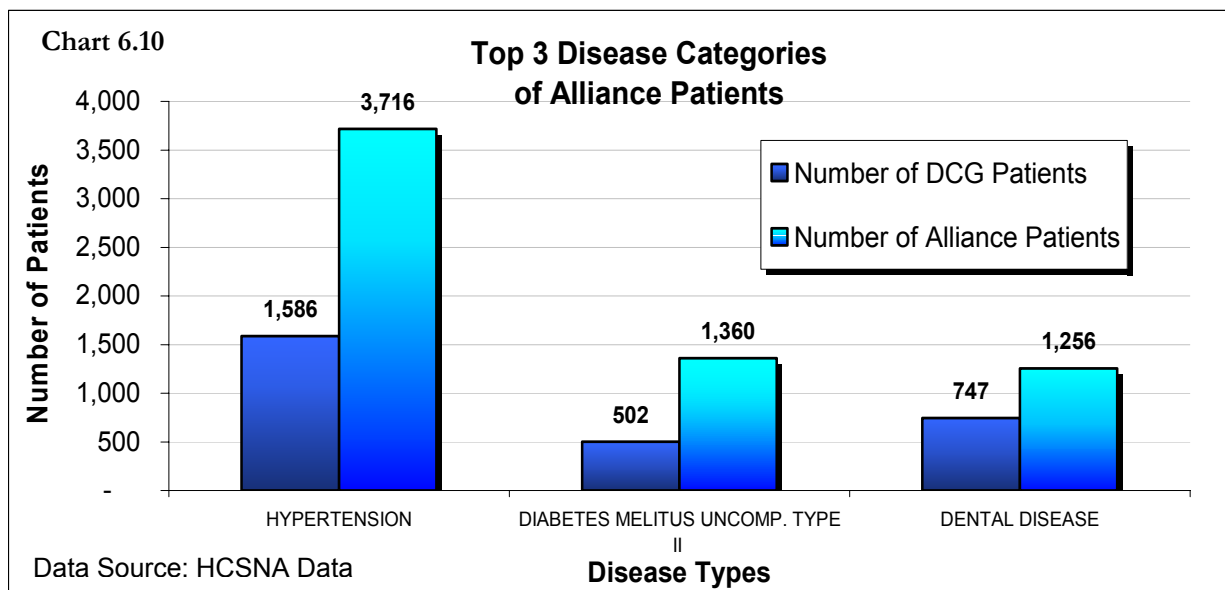
Diabetes is one of the top diagnosis within the Alliance and the DC General population. As a disease it presented itself in over 7 percent of the Alliance population served, or about 1,300 individual patient claims. This same group accounts for about 15 percent of the Alliance inpatient stays and was one of the leading reasons for unscheduled inpatient readmissions. In comparison, the DC General population reported diabetes in only 2 percent of the patient population served across service lines and represented a little over 500 patients, requiring 334 outpatient visits and

about 160 inpatient stays. Although the DCGH baseline data seems low, it is known that many diagnoses went unreported and some of the original data was unavailable for comparison.

Given the nature of diabetes and the ability to minimize its effects through early screening, patient education, and continued monitoring, one element the HCSNA looked at was the amount of HbA1c tests performed during Year 1.

Counts based upon claims data revealed that there were 444 tests performed on 1,883 individual patients. This means that roughly 24 percent of the Alliance patients that were treated were diagnosed with diabetes.

We cannot link now which patients received a test during their membership in the Alliance, or if the 444 includes multiple tests on the same patient. As the Alliance reporting mechanisms mature, such data will be available. This will permit better tracking and management of these conditions and implementation of best-practice clinical pathways for patients in



high-risk categories, such as foot exams for diabetic patients.

Patient education, the other element of diabetes prevention, unfortunately is not as positive. According to information provided by Chartered Health Plan (CHP), the entity contracted by the Alliance to perform patient education classes, only 13 individuals attended education classes from June to December 2001, and 23 attended from January to June 2002. These numbers are too low, but CHP does have a strategy to expand its outreach into the Alliance patient base for increased class attendance.

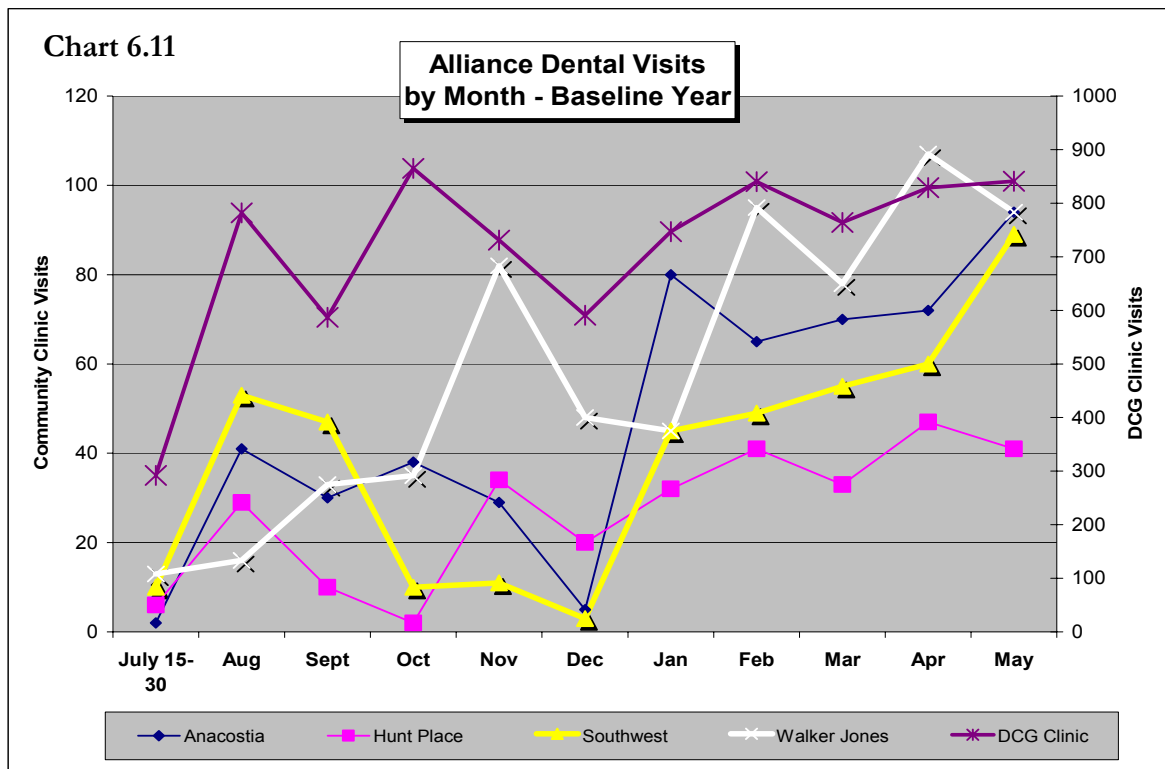
Dental Disorders

Rounding out the list of top diseases for the Alliance patient base is dental disease. Dental carries, pulpitis, and general periodontal disease across inpatient and outpatient settings presented itself in over 15 percent of the Alliance population served or almost 3,000 patients. There were 7,062 separate dental services performed on 5,518 Alliance members or over 11 percent of the

enrolled eligible population. Of those services, 320 or 4.5 percent were listed as preventative screens or services. Since the start of the Alliance, overall walk-in visit rates to dental clinics increased each month. Member access to dental services also increased. The Alliance population has access to the dental clinic on the DCGH campus, the five Unity clinics that provide dental services, Capitol Dental, the Greater SE Dental clinics, and some stand-alone providers.

Cancer

Cancer is a top health priority for the DC Department of Health's Healthy People 2010 initiative, and it is a prevalent disease within the Alliance patient population. There were almost 1,200 cancer diagnosis in 250 Alliance male patients, over six times the number of cancer diagnoses in males within the previous DCGH population. For women, it is about the same rate, 1,688 Alliance diagnoses in 509 patients as opposed to 267 diagnoses in 170 DCGH females patients. To determine if the



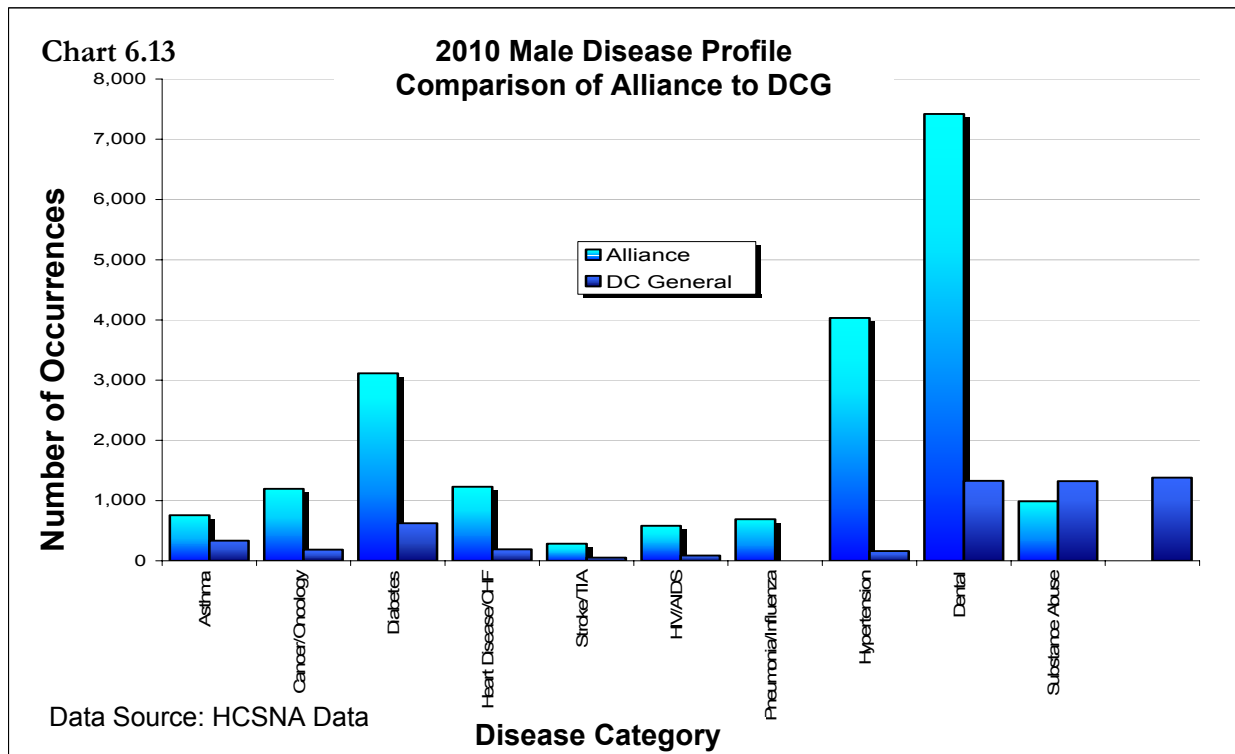
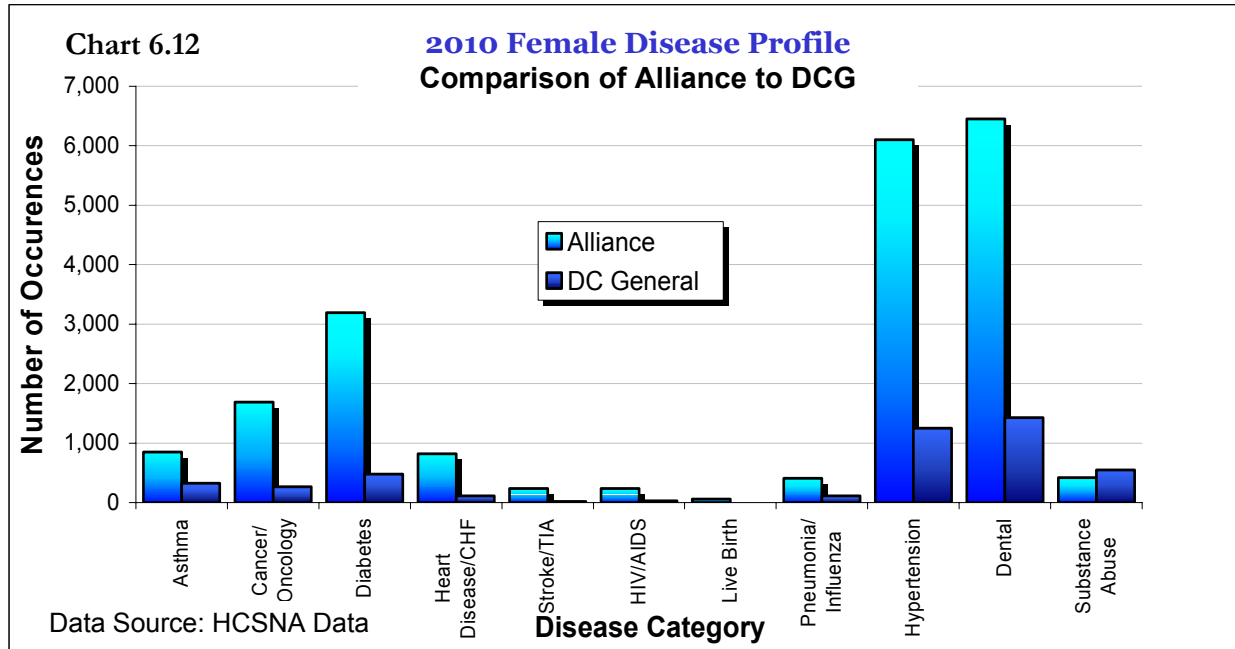
Alliance population is being treated better or if this disease is going undetected, the HCSNA reviewed the number of cancer screens performed, and that number's relation to the enrolled population.

The Alliance also tracks the number of screenings done for prostate cancer (PSAs) and for breast cancer (mammograms). As of this report, 318 mammograms and 177 PSAs were performed. This represents about 1 percent of the enrolled eligible population. Although this number is low, it is encouraging that Alliance members are being screened and treated.

HIV

HIV is a top diagnosis of Alliance patients upon admission to the hospital, as well as a top reason for unscheduled readmissions. The reason that the disease does not show up in the top three diagnoses is that the majority of this population qualifies for other programs that are not accounted for in Alliance claims data. However the Phoenix Center (the clinic which sees primarily infectious diseases) does report Alliance activity, and those visits were increasing each month.

In summary, while the numbers in some of these disease categories look small, more patients with these diagnoses exist whose claims have yet to be processed. Once a full year's worth of data is collected, more will be known about the categories and patterns of disease within the Alliance.



ALLIANCE SERVICES

Available healthcare benefit packages can be small or large, comprehensive or minimal, unique, or ordinary. The DC Healthcare Alliance offers a comprehensive and tailored benefit package to the uninsured District of Columbia residents who meet eligibility requirements. The wide range of benefits can be categorized into the following groups:

- Community-based primary care services
- Acute Care Services – Hospital inpatient, and emergency services
- Ancillary Support Services – Laboratory, pharmacy, and radiological services
- Care Management Support Services – Case/Disease management and health education.

Alliance Community-Based Care

One of the primary goals of the Alliance program is to promote preventative primary care services that the patient can obtain through a medical home. Towards this goal, the Alliance program matches each member with a primary care provider that is responsible for maintaining the health and wellness of the member. All services are coordinated through this primary care provider.

In the community-based setting, the Alliance provides dental, medical, and obstetrical services to individuals and families who meet eligibility criteria for membership in the program.

Services that are offered for pregnant women are: prenatal care, exams, tests, and education; hospital and delivery services; circumcision in the first 30 days; nurse midwife services; postpartum care; and care for a miscarriage.

Preventive dental services are very important in maintaining the overall health of patients and are covered under the Alliance program. Members have access to dental exams every 6 months; emergency care; cleaning and fluoride treatments every 6 months; dentures (minimum every 5 years) and denture repair; noncomplicated surgical extractions; fillings; and space maintainers as medically necessary. Oral surgery for emergency repair of accidental injury to the jaw, mouth, or teeth is also covered.

Acute Care

While the goal of the program is to promote wellness, it is recognized that any individual is susceptible to health risks and illnesses that may require urgent and intensive treatment. The Alliance consists of 6 hospitals and a free-standing Emergency Room that is able to meet the acute care needs of the uninsured population enrolled in the program.

The Alliance will provide for room and board to include: special diets in semi-private rooms; anesthesiology; consultations to specialty care; laboratory services and diagnostic testing; intensive care; rehabilitation services; general medical and surgical services; radiology services; operating room services; and transfusions.

Ancillary Support Services

Comprehensive care is given through each member's primary care provider by referrals to support services. Provision is made for members to receive services from pharmacy, laboratory, and radiology. Women are able to receive needed mammograms. Physical therapy, occupational therapy, speech therapy, and hearing services are also offered.

Wellness and Health Education Programs

The cornerstones of the Alliance are wellness and healthcare promotion. Many of its members suffer from preventable diseases and the Alliance has tackled these challenges by tailoring its Wellness Programs and Health Education classes to their specific needs. These programs are based on the premise that improved quality of life comes with promoting self-esteem and self-empowerment in attaining/maintaining healthy behaviors and making positive health care decisions. The goal of the Health Education Program is as follows:

Educate people about health behaviors, motivate the adoption of a healthy lifestyle, and enable an empowered role for members. A role of defining their problems, setting priorities, and creating practical solutions so that they achieve a sense of interest in, commitment to, and ownership of the efforts used to address their healthcare needs.

Health education programs are offered by Chartered Health Plan (CHP) to assist members understand their healthcare conditions, take care of themselves, and learn ways to improve their health. The Alliance targeted the most common health care conditions which included cellulitis, end-stage renal disease, pneumonia, diabetes, and cardiovascular disease. They designed programs to educate and improve the health of members with these conditions. The educational programs available through the Alliance include:

- Asthma care (pediatric and adult)
- Cardiovascular risk reduction (hypertension, high cholesterol)
- Chronic and end-stage renal support groups
- Diabetes care, preventative, and support

- HIV and STD prevention
- Men's health
- Nutrition and weight management
- Prenatal care
- Smoking cessation
- Women's health.

Initial education follows a prescribed methodology. Upon enrollment, members complete a health survey and a calendar of the offered classes is provided to them. The survey is reviewed and the member is invited to attend the classes that are pertinent to their condition. Classes are provided in either group or one-on-one sessions. A pretest is delivered to assess the member's knowledge and shape the class to the member's need. Behavioral change and maintenance plans are developed and post-testing takes place after the sessions. Referrals are also made if warranted. Follow-up evaluation of outcomes occurs at 3, 6, and 9 months.

To meet the varied population needs, classes are held at several Unity Health Care clinics, DC General outpatient facilities, CHP facilities, health fairs, and through a Wellness Van that delivers health education in scheduled community visits four times per month. In addition, the Wellness Program provides intensive outreach services to members who are difficult to reach or noncompliant with care.

These programs have been very successful for several disease programs, including diabetes; however, many of the other class offerings have been underutilized to date. The Alliance promotes the classes at health fairs, structured disease programs, and in the community. It encourages providers to direct patients to these free classes. For more information about the Alliance Wellness and Health Education Programs, please call (202) 842-2810.

Care Management Support Services

From the day the Alliance program went into operation, it was recognized that the uninsured population in the District of Columbia would present significant healthcare challenges. One particular challenge has been the severity of illness and the presence of multiple diseases in patients presenting for care services. Through Chartered Health Plan, the Alliance is equipped to provide a number of supportive care management services to these patients to promote wellness and to prevent the onset of episodes of serious illness in high risk patients.

Of all the diseases that have been identified, diabetes has consistently been among the top three diagnoses seen among Alliance patients. A significant number of these patients present with complications or co-morbidities requiring intensive and often expensive treatment in the hospital setting.

The Alliance program took aggressive steps to combat the problem of diabetes in the Alliance population. In October 2001, Chartered Health Plan initiated a targeted Diabetes Care Management Program that seeks to improve the healthcare status of patients suffering from the disease. Since that time, 115 patients with complicated diabetes were identified and enrolled into the program. A case manager provides intensive case coordination and health education for these patients. Through a specially developed database, clinical staff can track these patients through the care delivery system. By providing health education to the patients and appropriate clinical information to providers, including clinical guidelines, the program seeks to improve the quality of life of patients with the disease. With an increasing number of diabetics identified through care management efforts, the Alliance clinical leadership is actively seeking ways to enhance the diabetes program.

Recently, a contract was initiated with StayStat, an innovative Web-based health systems company, that provides wellness programs, health maintenance programs, educational programs, and other tools to assist providers, members, and case managers. The anticipated start date for integrating StayStat and its value-added services into the Diabetes Care Management Program is June 1, 2003. The three key goals that form the basis for this effort are as follows:

1. Through the use of Web-engineered applications, positively impact outcomes for a diabetic membership subset.
2. Integrate enrollment, claim, and provider data from the legacy MHC system with pharmacy data from Advance PCS utilization and laboratory data from Lab Corp utilization into a Web-based application.
3. Facilitate enhanced communication between members, case managers, and primary care physicians. Through innovative strategies and collaborative team-based involvement of physicians, case managers, health educators, and social workers, the Alliance expects to successfully coordinate and manage care for Alliance diabetic patients and is anticipating significant improvement in quality when it measures performance at the end of the year.

Recommendations

The Alliance providers strategically plan a mechanism to collaboratively ensure that the availability of all health education and wellness programs are compiled into one document that is disbursed among all the providers and the members.